

		FOR OHF USE					

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**2003**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF PUBLIC AID**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2003)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION  
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY  
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE  
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE  
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL  
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM  
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<b>I. IDPH Facility ID Number:</b> <u>0036079</u>		<b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b>	
<b>Facility Name:</b> <u>Warren Park Nursing Pavilion</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/03</u> to <u>12/31/03</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
<b>Address:</b> <u>6700 N. Damen Avenue</u> <u>Chicago</u> <u>60646</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
<b>County:</b> <u>Cook</u>		<b>Officer or Administrator of Provider</b> (Signed) _____ (Date) _____ (Type or Print Name) _____ (Title) _____	
<b>Telephone Number:</b> <u>(773) 465-5000</u> <b>Fax #</b> <u>(773) 743-5983</u>		<b>Paid Preparer</b> (Signed) _____ (Date) _____ (Print Name and Title) <u>Richard S. Sgarlata, C.P.A.</u> (Firm Name & Address) <u>Frost, Ruttenberg &amp; Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u> (Telephone) <u>(847) 236-1111</u> <b>Fax #</b> <u>(847) 236-1155</u>	
<b>IDPA ID Number:</b> <u>363693973001</u>		<b>MAIL TO: OFFICE OF HEALTH FINANCE</b> <b>ILLINOIS DEPARTMENT OF PUBLIC AID</b> 201 S. Grand Avenue East Springfield, IL 62763-0001 <b>Phone #</b> (217) 782-1630	
<b>Date of Initial License for Current Owners:</b> <u>03/01/90</u>			
<b>Type of Ownership:</b>			
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust <b>IRS Exemption Code</b> _____		<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input checked="" type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	
<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____			
<b>In the event there are further questions about this report, please contact:</b> <b>Name:</b> <u>Steve Lavenda</u> <b>Telephone Number:</b> <u>(847) 236 - 1111</u>			

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Park Nursing Pavilion# 0036079 Report Period Beginning: 01/01/03 Ending: 12/31/03

## III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>127</u>	Skilled (SNF)	<u>127</u>	<u>46,355</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>127</u>	TOTALS	<u>127</u>	<u>46,355</u>	7

## B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>4,747</u>	<u>204</u>	<u>1,431</u>	<u>6,382</u>	8
9	SNF/PED					9
10	ICF	<u>22,629</u>	<u>415</u>	<u>870</u>	<u>23,914</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>27,376</u>	<u>619</u>	<u>2,301</u>	<u>30,296</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 65.36%

D. How many bed-hold days during this year were paid by Public Aid?

None (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)N/A

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 03/10/90

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 03/10/90 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number  
of beds certified 11 and days of care provided 1,145Medicare Intermediary Mutual of Omaha

## IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH\* ☐ CASH\* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/03 Fiscal Year: 12/31/03

\* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

Page 3

Facility Name &amp; ID Number

Warren Park Nursing Pavilion

# 0036079

Report Period Beginning:

01/01/03

Ending:

12/31/03

**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	196,734	13,019	6,720	216,473		216,473		216,473		1
2	Food Purchase		168,102		168,102	(42,504)	125,598	(34)	125,564		2
3	Housekeeping	105,247	20,417		125,664		125,664		125,664		3
4	Laundry	39,864	8,743		48,607		48,607		48,607		4
5	Heat and Other Utilities			92,234	92,234		92,234	759	92,993		5
6	Maintenance	37,235	19,397	38,691	95,323		95,323	(3,552)	91,771		6
7	Other (specify):*							415	415		7
8	<b>TOTAL General Services</b>	379,080	229,678	137,645	746,403	(42,504)	703,899	(2,412)	701,487		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			4,200	4,200		4,200		4,200		9
10	Nursing and Medical Records	939,588	83,297	21,238	1,044,123		1,044,123	(9,439)	1,034,684		10
10a	Therapy		22	12,897	12,919		12,919		12,919		10a
11	Activities	66,449	3,773	1,817	72,039		72,039		72,039		11
12	Social Services	89,857		3,135	92,992		92,992		92,992		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,095,894	87,092	43,287	1,226,273		1,226,273	(9,439)	1,216,834		16
	<b>C. General Administration</b>										
17	Administrative	101,056			101,056		101,056	166,702	267,758		17
18	Directors Fees										18
19	Professional Services			285,538	285,538	(7,251)	278,287	(249,436)	28,851		19
20	Dues, Fees, Subscriptions & Promotions			28,438	28,438		28,438	(17,380)	11,058		20
21	Clerical & General Office Expenses	86,782	1,361	69,240	157,383		157,383	(1,059)	156,324		21
22	Employee Benefits & Payroll Taxes			285,204	285,204	42,504	327,708	(1,810)	325,898		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,582	1,582		1,582	418	2,000		24
25	Other Admin. Staff Transportation			4,183	4,183		4,183		4,183		25
26	Insurance-Prop.Liab.Malpractice			106,301	106,301		106,301	2,277	108,578		26
27	Other (specify):*							32,977	32,977		27
28	<b>TOTAL General Administration</b>	187,838	1,361	780,486	969,685	35,253	1,004,938	(67,311)	937,627		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,662,812	318,131	961,418	2,942,361	(7,251)	2,935,110	(79,162)	2,855,948		29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

## STATE OF ILLINOIS

Page 4

Facility Name &amp; ID Number

Warren Park Nursing Pavilion

#0036079

Report Period Beginning:

01/01/03

Ending:

12/31/03

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			44,581	44,581		44,581	156,630	201,211			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			43,596	43,596		43,596	159,128	202,724			32
33	Real Estate Taxes			124,421	124,421	7,251	131,672	(1,458)	130,214			33
34	Rent-Facility & Grounds			376,671	376,671		376,671	(376,671)				34
35	Rent-Equipment & Vehicles			12,434	12,434		12,434	3,966	16,400			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			601,703	601,703	7,251	608,954	(58,405)	550,549			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		39,538	35,049	74,587		74,587	(143)	74,444			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			69,533	69,533		69,533		69,533			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		39,538	104,582	144,120		144,120	(143)	143,977			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,662,812	357,669	1,667,703	3,688,184		3,688,184	(137,711)	3,550,473			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Warren Park Nursing Pavilion

# 0036079

Report Period Beginning: 01/01/03

Ending: 12/31/03

## VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	84,865	30		9
10	Interest and Other Investment Income	(31,522)	32		10
11	Discounts, Allowances, Rebates & Refunds	(2,264)	10		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(34)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(250)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(5,236)	21		24
25	Fund Raising, Advertising and Promotional	(15,991)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(44,000)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (14,433)</b>		<b>\$</b>	<b>30</b>

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(123,278)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ (123,278)</b>		<b>36</b>
37	<b>(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B) )</b>	<b>\$ (137,711)</b>		<b>37</b>

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			<b>\$</b>		<b>47</b>

SEE ACCOUNTANTS' COMPILATION REPORT

Report Period Beginning: 01/01/03  
Ending: 12/31/03

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1	COPY Does	\$ (1,827)	20 1
2	Bank Charges	(17,378)	21 2
3	Capitalizer R&M	(8,784)	00 3
4			4
5	Trust Fee	(150)	20 5
6	Bank Charges - Bldg Co	(125)	21 6
7	Franchise Tax	(200)	20 7
8			8
9			9
10	PPA - Office Expense	(9,563)	31 10
11	PPA - Employee Benefits	(1,810)	22 11
12	PPA - R&M	(248)	00 12
13	PPA - Nursing Supplies	(2,790)	10 13
14	PPA - Medicare	(20)	30 14
15	PPA - Equipment Rental	(1,105)	25 15
16			16
17			17
18			18
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98			98
99			99
100			100
101	Total	(44,000)	101

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Warren Park Nursing Pavilion

# 0036079

Report Period Beginning:

01/01/03

Ending:

12/31/03

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary													1
2	Food Purchase	(34)											(34)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities				759								759	5
6	Maintenance	(9,024)			605	4,867							(3,552)	6
7	Other (specify):*						415						415	7
8	<b>TOTAL General Services</b>	<b>(9,058)</b>			<b>1,364</b>	<b>4,867</b>	<b>415</b>						<b>(2,412)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records	(5,054)		(4,385)									(9,439)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	<b>TOTAL Health Care and Programs</b>	<b>(5,054)</b>		<b>(4,385)</b>									<b>(9,439)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative					166,702							166,702	17
18	Directors Fees													18
19	Professional Services		900		(250,336)								(249,436)	19
20	Fees, Subscriptions & Promotions	(18,418)	350		688								(17,380)	20
21	Clerical & General Office Expenses	(32,302)	(1,050)		27,750	4,543							(1,059)	21
22	Employee Benefits & Payroll Taxes	(1,810)											(1,810)	22
23	Inservice Training & Education													23
24	Travel and Seminar				418								418	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice				2,277								2,277	26
27	Other (specify):*				4,744		28,233						32,977	27
28	<b>TOTAL General Administration</b>	<b>(52,530)</b>	<b>200</b>		<b>(214,459)</b>	<b>171,245</b>	<b>28,233</b>						<b>(67,311)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(66,642)</b>	<b>200</b>	<b>(4,385)</b>	<b>(213,095)</b>	<b>176,112</b>	<b>28,648</b>						<b>(79,162)</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number **Warren Park Nursing Pavilion**# **0036079**

Report Period Beginning:

01/01/03

Ending:

12/31/03

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	84,865	69,199		2,566								156,630	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(31,522)	188,221		2,429								159,128	32
33	Real Estate Taxes		(3,300)		1,842								(1,458)	33
34	Rent-Facility & Grounds		(376,671)										(376,671)	34
35	Rent-Equipment & Vehicles	(1,105)			5,071								3,966	35
36	Other (specify):*													36
37	<b>TOTAL Ownership</b>	52,238	(122,551)		11,908								(58,405)	37
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers	(28)		(115)									(143)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	<b>TOTAL Special Cost Centers</b>	(28)		(115)									(143)	44
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	(14,433)	(122,351)	(4,500)	(201,187)	176,112	28,648						(137,711)	45



Facility Name & ID Number Warren Park Nursing Pavilion# 0036079

Report Period Beginning:

01/01/03

Ending:

12/31/03

## VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rental Income	\$ 376,671	Warren Park LLC		\$	\$ (376,671)	1
2	V	33 R/E Tax Over-Accrual	121,200	Warren Park LLC			(121,200)	2
3	V	33 Real Estate Tax Expense		Warren Park LLC		117,900	117,900	3
4	V	21 Bank Charges		Warren Park LLC		125	125	4
5	V	32 Interest Expense		Warren Park LLC		188,221	188,221	5
6	V	20 Trust Fees		Warren Park LLC		150	150	6
7	V	20 Franchise Tax		Warren Park LLC		200	200	7
8	V	30 Depreciation		Warren Park LLC		69,199	69,199	8
9	V	19 Accounting Fees		Warren Park LLC		900	900	9
10	V	21 Misc Income	1,175	Warren Park LLC			(1,175)	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 499,046			\$ 376,695	\$ * (122,351)	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Park Nursing Pavilion# 0036079Report Period Beginning: 01/01/03Ending: 12/31/03

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	10 MEDICAL SUPPLIES	17,372	LINCOLN MEDICAL SUPPLIES, INC.	100.00%	12,987	\$ (4,385)	15
16	V	39 ANCILLARY EXPENSE	457	LINCOLN MEDICAL SUPPLIES, INC.	100.00%	342	(115)	16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 17,829			\$ 13,329	\$ * (4,500)	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Warren Park Nursing Pavilion

# 0036079

Report Period Beginning: 01/01/03

Ending: 12/31/03

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	5 UTILITIES	\$	DYNAMIC HEALTH CARE CONS.	100.00%	\$ 759	\$ 759
16	V	6 REPAIRS & MAINT.				605	605
17	V	7 EMP.BEN. - GEN. SERVICES					
18	V	19 PROFESSIONAL FEES				2,064	2,064
19	V	20 DUES AND SUBSCRIPTIONS				688	688
20	V	21 CLERICAL & GENERAL				27,750	27,750
21	V	24 SEMINARS AND TRAVEL				418	418
22	V	26 INSURANCE				2,277	2,277
23	V	27 EMP.BEN. - GEN. ADMIN.				4,744	4,744
24	V	30 DEPRECIATION				2,566	2,566
25	V	32 INTEREST				2,429	2,429
26	V	33 REAL ESTATE TAXES				1,842	1,842
27	V	35 EQUIPMENT RENTAL				5,071	5,071
28	V						
29	V	19 PROFESSIONAL FEES	252,400				(252,400)
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 252,400			\$ 51,213	\$ * (201,187)

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Warren Park Nursing Pavilion**# **0036079**Report Period Beginning: **01/01/03**Ending: **12/31/03****VII. RELATED PARTIES (continued)**

**B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.** ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	6 MAINT. CMP. - D. NEHMER	\$	DYNAMIC HEALTH CARE CONS.	100.00%	\$ 4,867	\$ 4,867	15
16	V	17 ADMIN. CMP. - M. MAUER				27,088	27,088	16
17	V	17 ADMIN. CMP. - M. AARON				39,824	39,824	17
18	V	17 ADMIN. CMP. - F. AARON						18
19	V	17 ADMIN. CMP. - S. GOLDSTEIN				29,700	29,700	19
20	V	17 ADMIN. CMP. - S. KOPLIN				7,473	7,473	20
21	V	17 ADMIN. CMP. - D. MAGAFAS				7,482	7,482	21
22	V	17 ADMIN. CMP. - S. BOGEN				33,337	33,337	22
23	V	17 ADMIN. CMP. - S. LEVY				9,328	9,328	23
24	V	17 ADMIN. CMP. - HOWARD ALTER						24
25	V	17 ADMIN. CMP. - NON-OWNER				12,470	12,470	25
26	V	21 CLERICAL CMP. - S. AARON				4,543	4,543	26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 176,112	\$ * 176,112	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Warren Park Nursing Pavilion

# 0036079

Report Period Beginning: 01/01/03

Ending: 12/31/03

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	7 EMP. BEN.- D. NEHMER	\$	DYNAMIC HEALTH CARE CONS.	100.00%	\$ 415	\$ 415
16	V	27 EMP. BEN.- M. MAUER				860	860
17	V	27 EMP. BEN.- M. AARON				1,325	1,325
18	V	27 EMP. BEN.- F. AARON					
19	V	27 EMP. BEN.- S. GOLDSTEIN				15,696	15,696
20	V	27 EMP. BEN.- S. KOPLIN				2,827	2,827
21	V	27 EMP. BEN.- D. MAGAFAS				657	657
22	V	27 EMP. BEN.- S. BOGEN				2,730	2,730
23	V	27 EMP. BEN.- S. LEVY				1,349	1,349
24	V	27 EMP. BEN.- HOWARD ALTER					
25	V	27 EMP. BEN.- NON-OWNER				1,894	1,894
26	V	27 EMP. BEN.- S. AARON				895	895
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 28,648	\$ * 28,648

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Park Nursing Pavilion# 0036079Report Period Beginning: 01/01/03Ending: 12/31/03

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V	10A THERAPY	\$ 12,898	DYNAMIC REHAB CONSULTANTS, L.L.C.	100.00%	\$ 12,898	\$	15
16	V							16
17	V							17
18	V	39 ANCILLARY SERVICES	34,697	DYNAMIC REHAB CONSULTANTS, L.L.C.	100.00%	34,697		18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 47,595			\$ 47,595	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Park Nursing Pavilion# 0036079Report Period Beginning: 01/01/03Ending: 12/31/03

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Park Nursing Pavilion# 0036079Report Period Beginning: 01/01/03Ending: 12/31/03

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT



Facility Name & ID Number Warren Park Nursing Pavilion# 0036079Report Period Beginning: 01/01/03Ending: 12/31/03

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Park Nursing Pavilion# 0036079Report Period Beginning: 01/01/03Ending: 12/31/03

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

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Facility Name & ID Number Warren Park Nursing Pavilion # 0036079 Report Period Beginning: 01/01/03 Ending: 12/31/03

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Marshall Mauer	Owner	Administrative	6.30%	See Attached	2.90	5.80%	Alloc. Dynamic	\$ 27,088	17-7	1
2	Maury Aaron	Owner	Administrative	19.69%	See Attached	3.25	6.50%	Alloc. Dynamic	39,824	17-7	2
3	Sheila Bogen	Owner	Administrative	14.96%	See Attached	9.25	22.42%	Fac, Alloc Dyn	72,566	17-7, 17-1	3
4	Sharon Aaron	Relative	Clerical		See Attached	2.90	7.24%	Alloc. Dynamic	4,543	21-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 144,021		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).  
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME.  
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Park Nursing Pavilion# 0036079

Report Period Beginning:

01/01/03Ending: 12/31/03

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Park Nursing Pavilion# 0036079

Report Period Beginning:

01/01/03Ending: 12/31/03

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization LINCOLN MEDICAL SUPPLIES, INC.Street Address 3359 W. MAIN STREETCity / State / Zip Code SKOKIE, IL. 60076Phone Number ( 847) 679-8219Fax Number ( 847) 679-7377

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	<u>10</u>	<u>MEDICAL SUPPLIES</u>	<u>DIRECT ALLOCATION</u>					12,987	1
2	<u>39</u>	<u>ANCILLARY EXPENSE</u>	<u>DIRECT ALLOCATION</u>					342	2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 13,329	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Park Nursing Pavilion# 0036079

Report Period Beginning:

01/01/03Ending: 12/31/03

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization DYNAMIC HEALTH CARE CONS.Street Address 3359 W. MAIN STREETCity / State / Zip Code SKOKIE, IL. 60076Phone Number ( 847) 679-8219Fax Number ( 847) 679-7377

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5 UTILITIES	PATIENT DAYS	423,801	12	\$ 10,611	\$	30,296	\$ 759	1
2	6 REPAIRS & MAINT.	PATIENT DAYS	423,801	12	8,462		30,296	605	2
3	7 EMP.BEN. - GEN. SERVICES	PATIENT DAYS	423,801	12			30,296		3
4	19 PROFESSIONAL FEES	PATIENT DAYS	423,801	12	28,879		30,296	2,064	4
5	20 DUES AND SUBSCRIPTIONS	PATIENT DAYS	423,801	12	9,628		30,296	688	5
6	21 CLERICAL & GENERAL	PATIENT DAYS	423,801	12	388,179	279,093	30,296	27,750	6
7	24 SEMINARS AND TRAVEL	PATIENT DAYS	423,801	12	5,844		30,296	418	7
8	26 INSURANCE	PATIENT DAYS	423,801	12	31,856		30,296	2,277	8
9	27 EMP.BEN. - GEN. ADMIN.	PATIENT DAYS	423,801	12	66,362		30,296	4,744	9
10	30 DEPRECIATION	PATIENT DAYS	423,801	12	35,898		30,296	2,566	10
11	32 INTEREST	PATIENT DAYS	423,801	12	33,975		30,296	2,429	11
12	33 REAL ESTATE TAXES	PATIENT DAYS	423,801	12	25,761		30,296	1,842	12
13	35 EQUIPMENT RENTAL	PATIENT DAYS	423,801	12	70,935		30,296	5,071	13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 716,390	\$ 279,093		\$ 51,213	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Park Nursing Pavilion# 0036079

Report Period Beginning:

01/01/03Ending: 12/31/03

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization DYNAMIC HEALTH CARE CONS.Street Address 3359 W. MAIN STREETCity / State / Zip Code SKOKIE, IL. 60076Phone Number ( 847) 679-8219Fax Number ( 847) 679-7377

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	6	MAINT. CMP. - D. NEHMER	WGHTD. AVG. HOURS	40	9	59,901	59,901	3	4,867	1
2	17	ADMIN. CMP. - M. MAUER	WGHTD. AVG. HOURS	40	11	373,726	373,726	3	27,088	2
3	17	ADMIN. CMP. - M. AARON	WGHTD. AVG. HOURS	40	9	490,141	490,141	3	39,824	3
4	17	ADMIN. CMP. - F. AARON	WGHTD. AVG. HOURS	45	6	191,118	191,118			4
5	17	ADMIN. CMP. - S. GOLDSTEIN	WGHTD. AVG. HOURS	40	3	49,500	49,500	24	29,700	5
6	17	ADMIN. CMP. - S. KOPLIN	WGHTD. AVG. HOURS	40	7	69,097	69,097	4	7,473	6
7	17	ADMIN. CMP. - D. MAGAFAS	WGHTD. AVG. HOURS	45	9	77,417	77,417	4	7,482	7
8	17	ADMIN. CMP. - S. BOGEN	WGHTD. AVG. HOURS	11	2	40,545	40,545	9	33,337	8
9	17	ADMIN. CMP. - S. LEVY	WGHTD. AVG. HOURS	45	11	128,818	128,818	3	9,328	9
10	17	ADMIN. CMP. - HOWARD ALT	WGHTD. AVG. HOURS	40	1	12,000	12,000			10
11	17	ADMIN. CMP. - NON-OWNER	WGHTD. AVG. HOURS	45	11	153,735	153,735	4	12,470	11
12	21	CLERICAL CMP. - S. AARON	WGHTD. AVG. HOURS	40	11	62,676	62,676	3	4,543	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,708,674	\$ 1,708,675		\$ 176,112	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Park Nursing Pavilion# 0036079

Report Period Beginning:

01/01/03Ending: 12/31/03

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization DYNAMIC HEALTH CARE CONS.Street Address 3359 W. MAIN STREETCity / State / Zip Code SKOKIE, IL. 60076Phone Number ( 847) 679-8219Fax Number ( 847) 679-7377

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	7	EMP. BEN.- D. NEHMER	WGHTD. AVG. HOURS	40	9	5,106	3	415	1
2	27	EMP. BEN.- M. MAUER	WGHTD. AVG. HOURS	40	11	11,858	3	860	2
3	27	EMP. BEN.- M. AARON	WGHTD. AVG. HOURS	40	9	16,312	3	1,325	3
4	27	EMP. BEN.- F. AARON	WGHTD. AVG. HOURS	45	6	32,071			4
5	27	EMP. BEN.- S. GOLDSTEIN	WGHTD. AVG. HOURS	40	3	26,160	24	15,696	5
6	27	EMP. BEN.- S. KOPLIN	WGHTD. AVG. HOURS	40	7	26,142	4	2,827	6
7	27	EMP. BEN.- D. MAGAFAS	WGHTD. AVG. HOURS	45	9	6,801	4	657	7
8	27	EMP. BEN.- S. BOGEN	WGHTD. AVG. HOURS	11	2	3,320	9	2,730	8
9	27	EMP. BEN.- S. LEVY	WGHTD. AVG. HOURS	45	11	18,630	3	1,349	9
10	27	EMP. BEN.- HOWARD ALTER	WGHTD. AVG. HOURS	40	1	4,292			10
11	27	EMP. BEN.- NON-OWNER	WGHTD. AVG. HOURS	45	11	23,348	4	1,894	11
12	27	EMP. BEN. - S. AARON	WGHTD. AVG. HOURS	40	11	12,346	3	895	12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 186,386	\$		\$ 28,648	25

SEE ACCOUNTANTS' COMPILATION REPORT



Facility Name & ID Number Warren Park Nursing Pavilion# 0036079

Report Period Beginning:

01/01/03Ending: 12/31/03

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization DYNAMIC REHAB CONSULTANTS, L.L.C.  
 Street Address 3359 W. MAIN STREET  
 City / State / Zip Code SKOKIE, IL. 60076  
 Phone Number ( 847) 679-8219  
 Fax Number ( 847) 679-7377

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	<u>10A</u>	<u>THERAPY</u>	<u>DIRECT ALLOCATION</u>					12,898	1
2									2
3									3
4	<u>39</u>	<u>ANCILLARY SERVICES</u>	<u>DIRECT ALLOCATION</u>					34,697	4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 47,595	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Park Nursing Pavilion# 0036079

Report Period Beginning:

01/01/03Ending: 12/31/03

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Park Nursing Pavilion# 0036079

Report Period Beginning:

01/01/03Ending: 12/31/03

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Park Nursing Pavilion# 0036079

Report Period Beginning:

01/01/03Ending: 12/31/03

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Park Nursing Pavilion # 0036079 Report Period Beginning: 01/01/03 Ending: 12/31/03

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

**A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Devon Bank		X	Mortgage		6/1/95	\$	1,795,009			\$	188,221	1
2	MB Financial Bank		X	Note Payable				170,000				32,509	2
3													3
4													4
5	See Supplemental Schedule												5
	Working Capital												
6	MB Financial Bank		X	Line of Credit			700,000	386,750				8,216	6
7	Insurance		X				97,527					2,449	7
8	See Supplemental Schedule											2,851	8
9	TOTAL Facility Related						\$	797,527	\$	2,351,759			9
	B. Non-Facility Related*												
10													10
11	Interest Income		X									(31,522)	11
12													12
13	See Supplemental Schedule												13
14	TOTAL Non-Facility Related						\$		\$				14
15	TOTALS (line 9+line14)						\$	797,527	\$	2,351,759			15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$	\$			\$	1	
2												2	
3												3	
4												4	
5												5	
6												6	
7	TOTAL Long-Term											7	
	Working Capital												
8	MB Financial Bank		X	Working Capital			\$	\$			\$	422	
9	Allocated Dynamic		X									2,429	
10												10	
11												11	
12												12	
13												13	
14	TOTAL Working Capital											2,851	
	B. Non-Facility Related*												
15							\$	\$			\$	15	
16												16	
17												17	
18												18	
19												19	
20	TOTAL Non-Facility Related											20	

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

## B. Real Estate Taxes

**NOTES:**

1. Please indicate a negative number by use of brackets ( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. **This denial must be no more than four years old at the time the cost report is filed.**

**SEE ACCOUNTANTS' COMPILATION REPORT**



**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates    **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

**2002 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Warren Park Nursing Pavilion COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0036079

CONTACT PERSON REGARDING THIS REPORT : Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>11-31-302-043</u>	<u>Long Term Care Property</u>	\$ <u>74,923.63</u>	\$ <u>74,923.63</u>
2. <u>11-31-302-008</u>	<u>Long Term Care Property</u>	\$ <u>49,497.72</u>	\$ <u>49,497.72</u>
3. <u>10-23-404-059-0000</u>	<u>Home Office</u>	\$ <u>26,274.55</u>	\$ <u>1,878.27</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>150,695.90</u></u>	\$ <u><u>126,299.62</u></u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?   X   YES        NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates    **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

**2002 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Warren Park Nursing Pavilion COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0036079

CONTACT PERSON REGARDING THIS REPORT : Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
2.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
3.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
4.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
5.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
6.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
7.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
8.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
9.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
10.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
		<b>TOTALS</b>	\$ <u>                    </u>	\$ <u>                    </u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?            YES            NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

A. Square Feet:
43,400

B. General Construction Type:

Exterior
Brick

Frame

Number of Stories
3

C. Does the Operating Entity?

☐ (a) Own the Facility
☒ (b) Rent from a Related Organization.
☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒ (a) Own the Equipment
☒ (b) Rent equipment from a Related Organization.
☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES
☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		1985	\$ 158,750	1
2					2
3	TOTALS			\$ 158,750	3

SEE ACCOUNTANTS' COMPILATION REPORT

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	Various		1990		177,699		20	8,885	8,885	120,456	9
10	Various		1991		40,276		20	2,014	2,014	25,125	10
11	Various		1992		26,271		20	1,314	1,314	15,440	11
12	Various		1993		39,480		20	1,969	(1,969)	20,127	12
13	Various		1994		61,455		20	3,074	3,074	28,624	13
14	Various		1995		53,672		20	2,685	2,685	23,207	14
15	Various		1996		5,720		20	286	286	2,205	15
16	Various		1997		31,153		20	1,558	1,558	10,366	16
17	Various		1998		142,888		20	7,149	7,149	38,850	17
18	Various		1999		22,019		20	1,103	1,103	4,911	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37		\$	\$		\$	\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)	2,698,750	69,199		134,938	65,739	1,158,218		67
68	Related Party Allocations (Pages 12-REP & 12A-REP)	31,711	813		906	93	9,362		68
69	Financial Statement Depreciation		44,581			(44,581)			69
70	TOTAL (lines 4 thru 69)	\$ 3,331,094	\$ 114,593		\$ 165,881	\$ 47,350	\$ 1,456,891		70

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,331,094	\$ 114,593		\$ 165,881	\$ 51,288	\$ 1,456,891	1
2	Emergency Battery Li	2000	4,800		20	240	240	940	2
3	Refrigerator	2000	2,155		20	108	108	387	3
4	Elevator Upgrade	2000	2,182		20	109	109	372	4
5	Therapy	2000	115,660		20	5,783	5,783	20,722	5
6	Remodel Room & Hall	2000	13,178		20	659	659	2,361	6
7	Elevator Repair	2000	1,000		20	50	50	167	7
8	Parallel Bars	2000	902		20	45	45	143	8
9	Remodeling	2000	12,215		20	611	611	1,935	9
10	Beauty Salon Door	2000	626		20	31	31	97	10
11	Sewer Work	2000	2,350		20	118	118	363	11
12	Wallpaper	2000	1,127		20	29	29	88	12
13	Fire Alarm Repair	2000	3,353		20	86	86	262	13
14	Bathroom Fixtures	2000	561		20	14	14	45	14
15	Installation Of Outl	2001	7,175		20	359	359	1,017	15
16	Elevator Repair	2001	1,125		20	56	56	146	16
17	Draperies For Reside	2001	675		20	34	34	85	17
18	Tile	2001	1,139		20	57	57	147	18
19	Wiring On Ac Unit	2001	15,110		20	1,511	1,511	3,274	19
20	Cabinets	2001	10,150		20	1,015	1,015	2,199	20
21	Roof Repairs	2001	3,909		20	391	391	847	21
22	Wallpaper	2001	532		20	53	53	115	22
23	Sprinkler System	2001	923		20	24	24	70	23
24	Fire Alarm Repair	2001	709		20	18	18	52	24
25	Electrical Work	2001	625		20	16	16	39	25
26	Fire Alarm Repair	2001	533		20	53	53	124	26
27	Kithchen Ventilator	2001	752		20	19	19	46	27
28	Fire Repair	2001	1,215		20	122	122	273	28
29	Telephone System	2002	10,122		20	1,012	1,012	1,181	29
30	Sewer Pipe	2002	3,100		20	310	310	620	30
31	Chimney Reconstruct	2002	1,350		20	135	135	169	31
32	Electrical Outlet Installation	2002	1,800		20	180	180	195	32
33	Removal Of Trees	2002	1,800		20	180	180	270	33
34	TOTAL (lines 1 thru 33)		\$ 3,553,947	\$ 114,593		\$ 179,309	\$ 64,716	\$ 1,495,642	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 3,553,947	\$ 114,593		\$ 179,309	\$ 64,716	\$ 1,495,642	1
2	Glass Installation	2002	1,161		20	116	116	223	2
3	Install Emergency Light	2002	1,149		20	115	115	163	3
4	Patient Monitoring System	2003	14,634		20	854	854	854	4
5	Pagers And Watcher For Monitoring System	2003	830		20	83	83	83	5
6	Circuit For New Electric Stove	2003	850		20	57	57	57	6
7	Dedicated Circuit For Copier	2003	650		20	43	43	43	7
8	Security Cameras And Monitors	2003	2,355		20	98	98	98	8
9	Centrifical Roof Exhauster	2003	515		20	21	21	21	9
10	2 Centrifical Roof Exhausters	2003	1,054		20	44	44	44	10
11	Door Alarm	2003	695		20	17	17	17	11
12	Cameras, Etc	2003	1,175		20	20	20	20	12
13	Repair Cooler	2003	521		20	26	26	26	13
14	Building Material	2003	958		20	48	48	48	14
15	Sprinkler Heads And Splash Guards	2003	975		20	49	49	49	15
16	Rotary, Hinge Prep, Lite Kit, Glass	2003	1,241		20	62	62	62	16
17	Install New Thermostat, Clean Cond Unit	2003	545		20	27	27	27	17
18	Pump, Motor, Fan Blade	2003	786		20	39	39	39	18
19	Emergency Lights, Battery	2003	1,389		20	69	69	69	19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,585,430	\$ 114,593		\$ 181,098	\$ 66,505	\$ 1,497,586	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Warren Park Nursing Pavilion

STATE OF ILLINOIS

# 0036079

Report Period Beginning:

01/01/03

Ending:

Page 12D

12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 3,585,430	\$ 114,593		\$ 181,098	\$ 66,505	\$ 1,497,586	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,585,430	\$ 114,593		\$ 181,098	\$ 66,505	\$ 1,497,586	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.



XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 3,585,430	\$ 114,593		\$ 181,098	\$ 66,505	\$ 1,497,586	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,585,430	\$ 114,593		\$ 181,098	\$ 66,505	\$ 1,497,586	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 3,585,430	\$ 114,593		\$ 181,098	\$ 66,505	\$ 1,497,586	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,585,430	\$ 114,593		\$ 181,098	\$ 66,505	\$ 1,497,586	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 3,585,430	\$ 114,593		\$ 181,098	\$ 66,505	\$ 1,497,586	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,585,430	\$ 114,593		\$ 181,098	\$ 66,505	\$ 1,497,586	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 3,585,430	\$ 114,593		\$ 181,098	\$ 66,505	\$ 1,497,586	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,585,430	\$ 114,593		\$ 181,098	\$ 66,505	\$ 1,497,586	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 3,585,430	\$ 114,593		\$ 181,098	\$ 66,505	\$ 1,497,586	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,585,430	\$ 114,593		\$ 181,098	\$ 66,505	\$ 1,497,586	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1 Totals from Page 12I, Carried Forward		\$ 3,585,430	\$ 114,593		\$ 181,098	\$ 66,505	\$ 1,497,586		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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28									28
29									29
30									30
31									31
32									32
33									33
34 TOTAL (lines 1 thru 33)		\$ 3,585,430	\$ 114,593		\$ 181,098	\$ 66,505	\$ 1,497,586		34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)									
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
1	2	3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		\$ 3,585,430	\$ 114,593		\$ 181,098	\$ 66,505	\$ 1,497,586	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,585,430	\$ 114,593		\$ 181,098	\$ 66,505	\$ 1,497,586	34

XI. OWNERSHIP COSTS (continued)												
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.												
	1		2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4	127		1995		\$ 2,698,750	\$ 69,199		\$ 134,938	\$ 65,739	\$ 1,158,218	4	
5											5	
6											6	
7											7	
8											8	
	Improvement Type**											
9											9	
10											10	
11											11	
12											12	
13											13	
14											14	
15											15	
16											16	
17											17	
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28											28	
29											29	
30											30	
31											31	
32											32	
33											33	
34											34	
35											35	
36											36	

\*Total beds on this schedule must agree with page 2.  
 \*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-BLDG, Line 70 for total  
 SEE ACCOUNTANTS' COMPILATION REPORT



XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
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61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,698,750	\$ 69,199		\$ 134,938	\$ 65,739	\$ 1,158,218	70

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)												
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.												
	1	FOR OHF USE ONLY	2	3	4	5	6	7	8	9		
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4	Dynamic allocation		1993		\$ 31,711	\$ 813	35	\$ 906	\$ 93	\$ 9,362	4	
5											5	
6											6	
7											7	
8											8	
	Improvement Type**											
9											9	
10											10	
11											11	
12											12	
13											13	
14											14	
15											15	
16											16	
17											17	
18											18	
19											19	
20											20	
21											21	
22											22	
23											23	
24											24	
25											25	
26											26	
27											27	
28											28	
29											29	
30											30	
31											31	
32											32	
33											33	
34											34	
35											35	
36											36	

\*Total beds on this schedule must agree with page 2.  
 \*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total  
 SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)									
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
1	2	3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
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56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 31,711	\$ 813		\$ 906	\$ 93	\$ 9,362	70

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 143,995	\$ 698	\$ 14,359	\$ 13,661	10	\$ 79,095	71
72	Current Year Purchases	12,868	373	2,201	1,828	10	2,201	72
73	Fully Depreciated Assets	425,041				10	425,040	73
74								74
75	TOTALS	\$ 581,904	\$ 1,071	\$ 16,560	\$ 15,489		\$ 506,336	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	DODGE - MIDWAY	1993	\$ 21,583	\$	\$	\$	5	\$ 21,583	76
77	Facility	1999 Lexus RX300	2003	16,000		2,400	2,400	5	2,400	77
78	Alloc Dynamic	Alloc Dynamic	2003	4,024	681	1,152	471	5	3,944	78
79										79
80	TOTALS			\$ 41,607	\$ 681	\$ 3,552	\$ 2,871		\$ 27,927	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 4,367,691	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 116,345	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 201,210	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 84,865	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,031,849	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized  
by the length of the lease                     .

9. Option to Buy: ☐ YES ☐ NO Terms:                                     \*

**B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 10,632

Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	Lexus	\$	\$ 5,768	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 5,768	21

10. Effective dates of current rental agreement:

Beginning                     

Ending                     

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12.                      /2004 \$                     

13.                      /2005 \$                     

14.                      /2006 \$                     

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

**A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)**

<b>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</b>  <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	<b>2. CLASSROOM PORTION:</b>  IN-HOUSE PROGRAM <input type="checkbox"/>  IN OTHER FACILITY <input type="checkbox"/>  COMMUNITY COLLEGE <input type="checkbox"/>  HOURS PER AIDE _____	<b>3. CLINICAL PORTION:</b>  IN-HOUSE PROGRAM <input type="checkbox"/>  IN OTHER FACILITY <input type="checkbox"/>  HOURS PER AIDE _____
---	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

**C. CONTRACTUAL INCOME**

In the box below record the amount of income your facility received training aides from other facilities.

\$ \_\_\_\_\_

**D. NUMBER OF AIDES TRAINED**

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.  
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.  
 (c) For in-house training programs only. Do not include fringe benefits.  
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.  
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.  
**SEE ACCOUNTANTS' COMPILATION REPORT**

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 17,834	\$		\$ 17,834	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			703			703	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			16,512			16,512	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				24,457		24,457	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental						15,081		15,081	13
14	TOTAL			\$		\$ 35,049	\$ 39,538		\$ 74,587	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 527	\$ 5,067	1
2	Cash-Patient Deposits	67,690	67,690	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	512,965	522,965	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	37,908	37,908	6
7	Other Prepaid Expenses	6,367	6,367	7
8	Accounts Receivable (owners or related parties)	491,268	591,099	8
9	Other(specify): <a href="#">See Attached Schedule</a>	35,253	68,409	9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 1,151,978	\$ 1,299,505	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		158,750	13
14	Buildings, at Historical Cost		2,698,750	14
15	Leasehold Improvements, at Historical Cost	788,188	1,105,688	15
16	Equipment, at Historical Cost	284,933	284,933	16
17	Accumulated Depreciation (book methods)	(426,964)	(1,335,538)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	7,000	7,000	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(7,000)	(7,000)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):		(216,344)	22
23	Other(specify): <a href="#">See Attached Schedule</a>	216,439	216,439	23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 862,596	\$ 2,912,678	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 2,014,574	\$ 4,212,183	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 222,764	\$ 222,764	26
27	Officer's Accounts Payable	429,200	429,200	27
28	Accounts Payable-Patient Deposits	67,690	67,690	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	127,089	127,089	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,443	2,443	31
32	Accrued Real Estate Taxes(Sch.IX-B)	127,000	127,000	32
33	Accrued Interest Payable	1,469	143,427	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	3,466	3,466	35
	<b>Other Current Liabilities(specify):</b>			
36	<a href="#">See Attached Schedule</a>	32,138	32,138	36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 1,013,259	\$ 1,155,217	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	556,750	2,351,759	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<a href="#">See Attached Schedule</a>			43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 556,750	\$ 2,351,759	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 1,570,009	\$ 3,506,976	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 444,565	\$ 705,207	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 2,014,574	\$ 4,212,183	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)



**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	<b>\$ 780,498</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Prior Year Depreciation Adjustment</b>	<b>(9,698)</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	<b>\$ 770,800</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(326,235)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	<b>( )</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	<b>\$ (326,235)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	<b>\$</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	<b>\$ 444,565</b>	<b>24 *</b>

\* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.  
**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 3,288,638	1
2	Discounts and Allowances for all Levels	(205,278)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,083,360	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	173,100	6
7	Oxygen	9,614	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 182,714	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	35,690	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	4,670	19
20	Radiology and X-Ray	1,253	20
21	Other Medical Services	20,183	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 61,796	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	31,522	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 31,522	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	See Supplemental Schedule	2,557	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 2,557	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 3,361,949	30

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	746,403	31
32	Health Care	1,226,273	32
33	General Administration	969,685	33
	<b>B. Capital Expense</b>		
34	Ownership	601,703	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	74,587	35
36	Provider Participation Fee	69,533	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 3,688,184	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(326,235)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (326,235)	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Cash Basis If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **Warren Park Nursing Pavilion**# **0036079**Report Period Beginning: **01/01/03**Ending: **12/31/03**

## XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,962	2,165	\$ 55,406	\$ 25.59	1
2	Assistant Director of Nursing	993	1,111	24,923	22.43	2
3	Registered Nurses	13,836	14,655	303,546	20.71	3
4	Licensed Practical Nurses	6,346	6,738	124,571	18.49	4
5	Nurse Aides & Orderlies	45,760	49,321	418,149	8.48	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,762	1,902	28,238	14.85	9
10	Activity Assistants	5,197	5,324	38,211	7.18	10
11	Social Service Workers	6,476	7,076	89,857	12.70	11
12	Dietician					12
13	Food Service Supervisor	1,914	2,117	35,179	16.62	13
14	Head Cook	8,072	8,744	81,814	9.36	14
15	Cook Helpers/Assistants	9,794	10,484	79,741	7.61	15
16	Dishwashers					16
17	Maintenance Workers	1,960	2,219	37,235	16.78	17
18	Housekeepers	12,526	13,496	105,247	7.80	18
19	Laundry	5,131	5,667	39,864	7.03	19
20	Administrator	3,106	3,181	86,631	27.23	20
21	Assistant Administrator	603	859	14,425	16.79	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,778	7,101	86,782	12.22	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	902	942	12,993	13.79	31
32	Other Health Care(specify)					32
33	Other(specify) <a href="#">See Supplemental</a>					33
34	TOTAL (lines 1 - 33)	133,118	143,102	\$ 1,662,812 *	\$ 11.62	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

## B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	267	\$ 6,720	01-03	35
36	Medical Director	84	4,200	09-03	36
37	Medical Records Consultant	32	1,376	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	85	3,400	10-03	39
40	Physical Therapy Consultant	164	5,742	10a-03	40
41	Occupational Therapy Consultant	157	5,508	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	47	1,647	10a-03	43
44	Activity Consultant	44	1,817	11-03	44
45	Social Service Consultant	57	3,135	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	937	\$ 33,545		49

## C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	303	\$ 11,672	10-03	50
51	Licensed Practical Nurses	125	4,790	10-03	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	428	\$ 16,462		53

SEE ACCOUNTANTS' COMPILATION REPORT

## XIX. SUPPORT SCHEDULES

[illegible]

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

**\*\*See instructions.**

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS** (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

1		2		3		4		5		6		7		8		9		10		11		12		13	
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year																				
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008												
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
2																									
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20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Warren Park Nursing Pavilion

STATE OF ILLINOIS

# 0036079

Report Period Beginning:

01/01/03

Ending:

Page 23

12/31/03

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. IL Council - \$7,310
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 2,281 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 69,533  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 42,504 Has any meal income been offset against related costs? No Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 14  
d. Have vehicle usage logs been maintained? Yes  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
g. Does the facility transport residents to and from day training? No  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.